Mr. Turner
365-4315

SUBMISSION

to

MEDICAL SERVICES INSURANCE ENQUIRY

Province of Ontario

Prepared by

CANADIAN HEALTH INSURANCE ASSOCIATION

TORONTO, ONTARIO

Non-profit carriers — or. {prepaid / doctor-sponsored}
——//——
Multiplicity of carriers. } Want to take statement about health before determining size of premium.
" " plans. }

Commercial carriers can provide better service etc. because of competition, profit motive etc.

Over 65's. — pooling to minimize losses.
- profit however in salesmans fee for selling policies.

P 41 - p. 18. ? why segregate indigent group.

Non-profit plans — $11.50/6 months. — P.S.I. — no age limit or other condition.
also 10% subsidy by profession.

CANADIAN HEALTH INSURANCE ASSOCIATION

SUITE 1910, 25 KING ST. WEST, TORONTO 1, CANADA
EMPIRE 6-9486

CORBET L. DREWRY, M.B.E., LL.B.
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ROSS R. ROWLANDS, EXECUTIVE ASSISTANT
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November 14, 1963.

Dr. J. G. Hagey,
Chairman,
Medical Services Insurance Enquiry,
Room 418, 67 College St.,
Toronto 1, Ontario.

Dear Dr. Hagey:

It is with pleasure that I send you, herewith, the Submission of our Association, together with twenty-five additional copies as required for Enquiry purposes.

The following have been selected by the Association's Executive Committee to appear before the Enquiry on behalf of CHIA:

Mr. G. R. Berry Metropolitan Life Insurance Company	President, CHIA
Mr. R. N. Mackintosh Zurich Insurance Company	Vice-President, CHIA
Dr. J. C. Emmett The Imperial Life Assurance Company of Canada	Co-Chairmen of CHIA's Committee on Medical Services Insurance
Mr. G. N. Watson The Crown Life Insurance Company	
Mr. A. H. Jeffery, Q.C. The London Life Insurance Company	Chairman, CHIA's Legislative Committee
Mr. Corbet L. Drewry Canadian Health Insurance Assn.	

The above delegation will also be accompanied by a small group of technical people. Principal spokesmen for the Association will be myself as President and Mr. Watson.

We look forward to appearing before the Enquiry at its hearings in Toronto, and to discussing with the Enquiry members at that time the proposals set out in the attached Submission.

Yours very truly,

George R Berry

GEORGE R. BERRY
PRESIDENT

GRB::md
encs.

Insurance cos. All policies that cover nurses, drugs, appliances, etc. & do not feel limited to supplying or selling physicians services only. Bill 163 - MDs only.

Canadian Health Insurance Association

TABLE OF CONTENTS

SUMMARY AND RECOMMENDATIONS

1. As spokesmen for the Canadian Health Insurance Association, we greatly appreciate the opportunity to appear before this Enquiry.

2. Our Association, founded in 1959, comprises 116 member companies in the life, personal accident and sickness, and general insurance fields and accounts for more than 96 percent of the voluntary health insurance provided by insurance companies in Canada. Particulars of the nature and objectives of the Association, together with a complete list of our membership and Executive, are given in Appendix I.

3. The members of CHIA speak from many years of experience in the insurance field and more specifically from a background of several decades of providing voluntary health insurance coverage for growing numbers of Canadians. Through the years we have worked to develop and implement ever-broader coverages to meet the changing needs of Canadians for health insurance.

4. In the statement of policy of our Association the following appears: "With full realization of the need for co-operative action by all interested groups, the health insurance business pledges itself to co-operate with the medical profession and other suppliers of health care, as well as governments and organizations interested in the public

health, to provide the best possible standard of health care and the greatest possible protection against the cost of ill health."

5. The Association was formed in the belief that the high quality of medical care now available to most Canadians can best be maintained and improved for present and future generations by a continuation of the present voluntary system, and financing a large part of its cost through prepaid medical insurance.

6. The Association is very well aware that some segments of the population are not in a financial position to pay even a most reasonable premium for voluntary medical insurance. Such persons, it feels, will continue to require financial assistance from the governments or others; it believes, however, that it is unrealistic and unnecessary to institute overall, compulsory, government-sponsored plans applicable to the entire population just to care for this relatively limited group.

7. At the present time, some 10 million Canadians - slightly more than half the population of the country - are insured for medical services insurance in voluntary plans provided by the life, personal accident and sickness, and general insurance companies and through voluntary plans sponsored by medical associations and certain co-operative organizations.

8. The Association firmly believes that these figures not only reflect the tremendous increase in the demand for voluntary

health insurance in recent years, but are indicative of the confidence of the public in existing plans.

9. The Association maintains that voluntary plans of this type protect the free choice of doctor by the patient and vice versa, and do not in any way interfere with their relationship with one another. These incalculable benefits would be preserved in any proposed extension of present voluntary plans to include currently ineligible groups and individuals. The insurance industry recognizes that only doctors can provide medical care and that the role of insurance companies is only to help devise the means of financing the cost of such care.

10. Since its formation four and a half years ago, our Association has worked diligently to provide and expand medical care benefits. It is convinced that with the co-operation of all parties concerned, the present voluntary plans can be modified and improved to finance this same high standard of medical care through voluntary health insurance at a reasonable premium cost to all Canadians, regardless of age, health or occupation, and accomplished without involving governments at either the federal or provincial level in substantial new costs and extensive new administrative machinery.

11. It is in this context that we address ourselves today, not only to the specifics of the Ontario Medical Services Insurance

Bill, but also to the broader consideration of the program envisaged by that Bill.

12. Our Association appeared before the federal Royal Commission on Health Services in May and October of 1962. On both occasions we expressed our firm belief that the most efficient, satisfactory and economical method of making health insurance available to all Canadians was through the extension and improvement of the voluntary insurance mechanism.

13. Recently two provinces have implemented legislation to make medical services insurance available to their citizens regardless of their age, the condition of their health, their occupation or ability to pay. In Saskatchewan and Alberta two fundamentally different approaches for making medical services insurance available to entire populations were adopted. Both approaches have been the subjects of major studies by our Association, and our conclusions are reflected in our endorsation of Ontario's proposal and the suggestions contained in this submission.

14. During the debate on Bill 163 in the Ontario legislature on April 25th, the Honourable Dr. Dymond outlined five governing principles which the government holds essential to the successful achievement of a sound, equitable and adequate Plan of health insurance for the people of Ontario.

These were:

(1) The Plan should be available to every citizen and his dependants who are residents, without regard to age, physical or mental infirmity, means or occupation.

(2) Coverage under the Plan should be non-cancellable and guaranteed renewable.

(3) There shall be no compulsion upon anyone to purchase or acquire coverage.

(4) The government should accept responsibility for those who cannot make provision for their own medical health care.

(5) Insurance should be available from the carrier of the insured's choice.

15. Although, as insurers, we harbour some reservations regarding the soundness of the form of some of the benefits to be provided under the standard medical services insurance contract (e.g. the form of the psychiatric benefits), we nevertheless wholeheartedly endorse the Plan envisaged by Bill 163 as implementing the principles enunciated by the Minister and align ourselves solidly in support of it.

16. The purpose of this Enquiry, as we understand it, is to entertain the views and comments of interested individuals and organizations on Bill 163 and to report and make recommendations based on the Enquiry's findings to assist the government in its efforts to implement most satisfactorily and efficiently the program stated in the Bill. With our extensive experience over the years in the provision of health insurance programs, and mindful of the policy of our Association, we feel it our duty

to comment on Bill 163 and respectfully to offer our suggestions which we earnestly hope will prove of some assistance.

17. We have listed these five aspects upon which we wish to comment and offer our suggestions as follows:

A - Suggestions regarding the organizational structure required to administer the Plan.

B - An explanation of the necessity for pooling arrangements.

C - Suggestions regarding the inclusion of a plan with co-insurance and deductibles in place of the standard in-hospital contract.

D - Suggestions regarding the application of a Government subsidy and the identification of the residents eligible for it.

E - Further suggested amendments to the provisions of Bill 163.

SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

As requested by the Enquiry we summarize here the main conclusions and recommendations developed in the submission which follows:

1. Achievement of the objectives of Bill 163 requires the continuous cooperative efforts of the government, the medical profession and the carriers. In our opinion an appropriate organizational structure should be established to provide for this. We accordingly recommend that suitable provisions be included in the legislation

to establish the necessary organizational structure providing representation, where appropriate, from government, the profession and the carriers. Included in this structure should be a policy-making body to be called the COORDINATING DIRECTORATE; a technical agency to be known as MEDICAL CARRIERS INCORPORATED which is already in part envisaged by the provisions of the Bill; and a suitable committee to be known as the REVIEW COMMITTEE to handle problems between the profession and carriers (see Section A).

2. Because of the possible financial hazards involved by reason of the obligation imposed by the legislation to provide standard coverage for high-cost risks at premiums which may not exceed stipulated maximums, and in order to guarantee that carriers will participate vigorously in the promotion of the program, we believe it is essential to set up a pooling arrangement through a central risk-sharing agency. This we regard as the chief purpose of Medical Carriers Incorporated. We therefore recommend the inclusion of appropriate provisions in the legislation to provide for this pooling arrangement and the machinery to administer it. We further recommend that the following maximum premiums be included in the

Bill in place of the symbols presently shown:

	Standard Medical Services Insurance Contract	Standard Medical Services Co-Insurance Contract
Individual	$6.25	$4.00
Family of Two	$12.50	$8.00
Family of Three or More	$16.00	$11.00

It should be emphasized that these suggested figures are maximums beyond which no carrier may charge, and they must not be taken to represent the premium charge which will be made to everyone for this coverage. Many contracts will undoubtedly be issued at premiums less than the maximum, reflecting the competition among the carriers--all being free to charge whatever premiums may seem to them appropriate to the risk, so long as the premium charged does not exceed the maximum. (See Section B)

3. While we believe that the standard medical services insurance contract with benefits as outlined in Schedule A fulfills the objectives of government, we have some reservations about the suitability of the in-hospital contract in view of the serious problems it poses in doctor-patient relationships, in public relations with patients, in hospital utilization and bed availability,

and in administration. We therefore recommend that the standard in-hospital medical services insurance contract be replaced by a standard medical services co-insurance contract providing the same benefits as the standard medical services insurance contract as outlined in Schedule A but with a co-insurance and deductible arrangement (see Section C).

4. Section 3 (a) of the Bill authorizes the Minister to pay the full cost of coverage to those in needy circumstances and in receipt of assistance under one of more of the Acts listed in Schedule C. We understand these people are presently handled under the Ontario Medical Welfare Plan which has been functioning effectively for a number of years, and accordingly it would seem to us advantageous for the time being not to disturb this machinery. However, if the government desires and the medical profession concurs, consideration might be given to providing benefits identical to those of the standard medical services insurance contract which are higher than present benefits under the Medical Welfare Plan. We think any such arrangement should be kept out of the program under Bill 163 and quite separate from Medical Carriers Incorporated and outside any

pooling arrangement. (See Section D)

5. Section 3 (b) of the Bill authorizes the Minister to provide partial assistance to people in needy circumstances not in receipt of assistance under any of the Acts in Schedule C - although the group is not further delineated. Our consideration of all sides of this question has resulted in the following suggestions:

   -that income testing be the basis of identifying those to be subsidized;

   -that persons whose incomes are less than 100% of the personal exemptions as set out in the Income Tax Act be eligible for subsidy;

   -that there be only one level of subsidy for this group;

   -that the subsidy take the form of a fixed dollar amount applied towards the premium.

   We have outlined a method of subsidy administration which is relatively simple and which makes use of existing machinery. (See Section D)

6. Having made a detailed study of the Bill we are suggesting a number of amendments, many of which are purely technical. These are set forth in detail in Appendix II. We recommend amendment of the Bill in the manner indicated.

7. While having some doubts as insurers about the soundness of the form of certain of the benefits to be provided by the standard medical services insurance contract, we nevertheless wholeheartedly endorse the Plan envisaged

by the Bill. Accordingly, we strongly recommend that, subject to the changes advocated in this submission being made, the Ontario Medical Services Insurance Bill be enacted as soon as possible.

S U B M I S S I O N

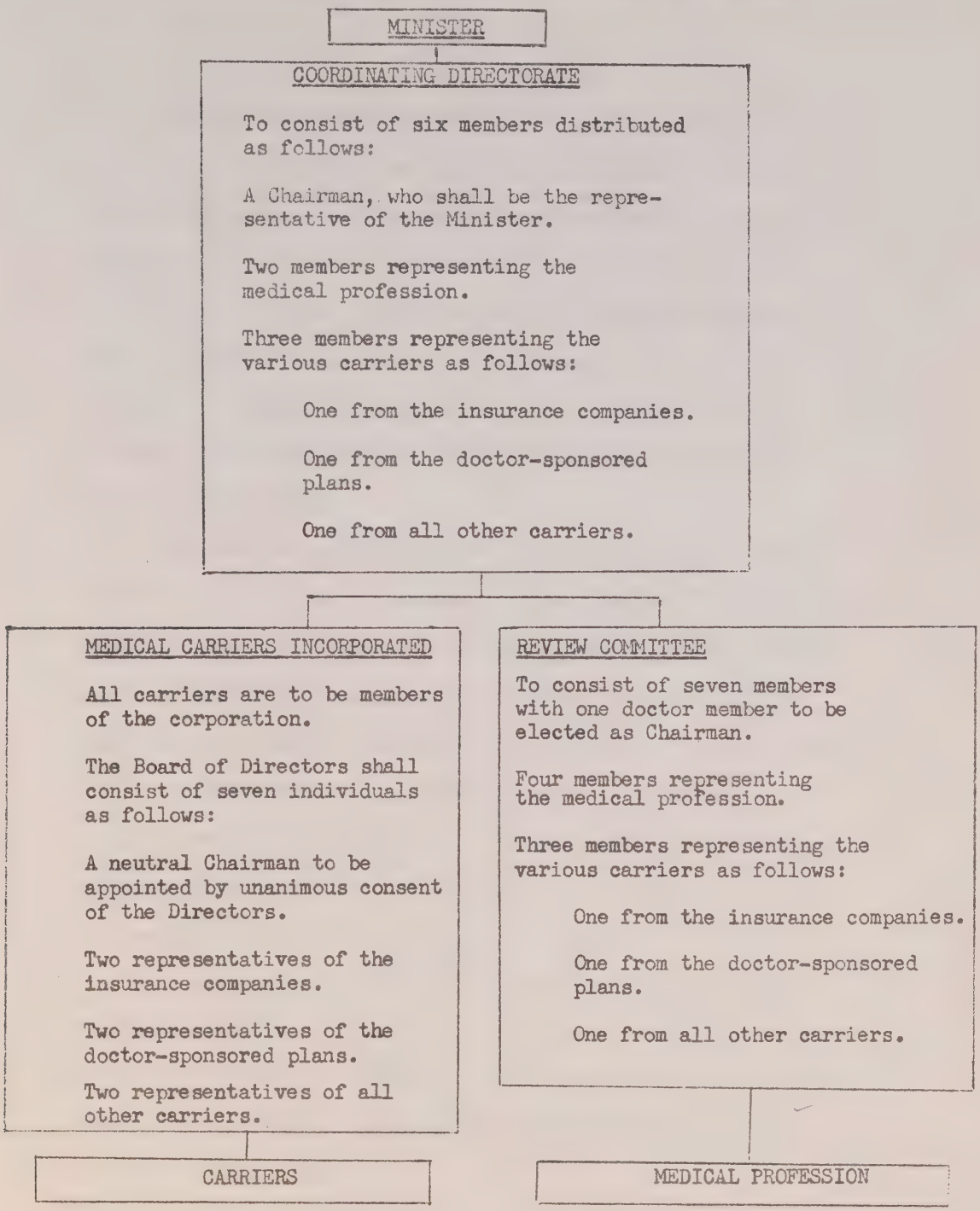
SECTION A

SUGGESTIONS REGARDING THE ORGANIZATIONAL STRUCTURE REQUIRED TO ADMINISTER THE PLAN

1. Achievement of the objectives of Bill 163 requires the continuous cooperative efforts of the Government of Ontario, the medical profession and the various types of carriers. Each is involved in some aspects of the Plan and the smooth coordination of the activities of each - not only in the early stages but on a continuing basis - is vital to its successful operation. An appropriate organizational structure, therefore, is important and we would like to make some observations and suggestions in this area.

2. As the Bill presently stands, the only organization mentioned is Medical Carriers Incorporated (hereafter referred to as MCI). In Alberta, a more extensive organizational structure has been worked out and described in the Regulations of the Alberta Medical Plan. Having carefully considered the Alberta pattern, we are suggesting a somewhat similar structure in a form we believe to be appropriate for Ontario. This is outlined in chart form on the following page. We believe that suitable provisions should be added to the Bill to establish the necessary committees or other bodies. These are not included in the redrafted provisions set forth in Appendix II but we will be glad to suggest appropriate wordings if asked to do so.

CHART SHOWING SUGGESTED ORGANIZATIONAL STRUCTURE FOR ONTARIO



3. The Coordinating Directorate, as proposed, is the necessary policy-making body, and provides machinery for bringing together the views, recommendations and experience of the three main parties involved in the operation of the Plan, i.e., the Government of Ontario (or the appropriate Department responsible for administering financial assistance), the medical profession (which is rendering the medical care), and the carriers (which are responsible for furnishing the means of financing such care).

4. This Coordinating Directorate will be the channel through which all information and recommendations flow to the responsible Minister not only from the Directorate itself, but also from MCI, from the Review Committee, and from any other organization or committee established to assist in the implementation of the Plan.

5. The Coordinating Directorate should also function as the advisory body to the Minister in all cases where he is seeking information or requires or desires advice on problems on which he considers action should or might be taken.

6. The composition of the Coordinating Directorate is most important and should, we believe, be as set forth in the chart on the preceding page. Because it is important that the Minister should at all times have the benefit of the views of all the

different interests represented on the Coordinating Directorate, alternates should be named for each member. For the same reason it should be clearly established that every member must be present or represented by his alternate at all meetings of the Coordinating Directorate.

7. References in the Bill to MCI clearly establish its character as an association of the carriers which are providing the medical services insurance. Its functions are purely technical and administrative and its purpose is to coordinate the activities of the various carriers. Its scope is limited to the operating level of the Plan - it is not, nor should it be, a policy-forming body. Therefore, neither government nor the medical profession is included in its structure. A more precise outline of the functions of MCI may be helpful at this stage. As we see it, these functions would be:

(1) To consider and set maximum premium rates for the contracts described in the Bill.

(2) To set an initial open enrolment period and such enrolment procedures as seem advisable.

(3) To determine the qualifications for membership in MCI.

(4) To administer a pooling arrangement which shall be mandatory on all members unless exempted under the regulations of MCI as described later in this submission.

(5) to deal with such other matters as relate to the technical administration of the proposed Plan.

8. The Review Committee should deal with and mediate on problems arising between the physicians and the carriers, which cannot be resolved in the regular course of administration. It should provide a forum for discussing broad problems affecting each group, and specific matters such as a doctor wishing to raise some problem with an individual carrier or a carrier desiring to explore a situation with an individual doctor, or on matters of claim abuse or misuse.

9. It is our understanding that adequate machinery currently exists in the medical profession to deal with and mediate on any problems that may arise between a covered person and his physician.

SECTION B

AN EXPLANATION OF THE NECESSITY FOR POOLING ARRANGEMENTS

10. We have already referred to the five principles enunciated by the Minister of Health which Bill 163 was designed to satisfy. The first principle is that the Plan should be available to every citizen and his dependants who are residents, without regard to age, physical or mental infirmity, means or occupation. The fifth principle is that medical services insurance should be available from the carrier of the insured's choice. In order to achieve the objectives of these two principles it is necessary to set up a pooling arrangement through a central risk-sharing agency. This we regard as the chief purpose of MCI.

11. Before explaining how the pooling arrangement will operate in practice, let us consider the principal factors which make it necessary.

12. In making the Plan available to all, regardless of age, health, means or occupation - and also to satisfy the other principles stated by the Minister of Health - the carriers will insure a large number of high-cost risks, a fact which has been borne out by the experience so far in Alberta. These high-cost risks are the aged and those in such poor health as to require a large amount of medical care.

13. However, Bill 163 provides that maximum premiums be established and the concept is that these maximum premiums be kept at levels which will be within the competence of most people to pay. No one will have to pay more than these amounts regardless of how high-cost a risk he may be. In the Bill at present, maximum premiums are merely indicated by symbols and not figures. CHIA's recommendations for the maximum premium figures to be included in the legislation are set out in Appendix II of this submission. The suggested figures have, of course, been determined in accordance with the foregoing principles and concepts and it must be recognized that at these premium levels the high-cost risks as a group will in total produce a loss. The pooling arrangement described herein is designed to share this loss equitably among all participating carriers.

14. To ensure that medical services insurance will be energetically presented to the whole population of Ontario and to provide medical services insurance in Ontario on the broad base contemplated, and to preserve for the public the widest possible choice, it is essential that as many carriers as possible be encouraged to offer the standard contracts, vigorously promote the Plan, and seek out those

who would benefit from it.

15. The pooling arrangement is therefore also designed to encourage participation by that class of carrier for which medical services insurance is only part of its business. To make the Plan a success it is highly desirable that these carriers also play their full part.

16. With the pooling arrangement there is every reason for carriers of every type to promote the Plan as each will be protected regardless of how large a proportion it insures of the high-cost risks. (This class can certainly be expected to enrol with alacrity.)

17. Through pooling we can be sure that any carrier which aggressively seeks to enrol the largest number of residents in the Plan will not suffer financially as compared to the carrier which does little or nothing to promote the Plan, since the latter will in any event have to bear its full share of the losses of the pool of high-cost risks.

18. Here is the way the pooling arrangement will operate.

19. Maximum premiums will be stipulated and contracts of medical services insurance of the standard forms as set forth in Bill 163 and as modified by the suggestions of this submission can only be issued at a premium rate which does not exceed these maximum premiums. If a contract is issued at the

maximum premium, the insurer is required to place that contract in the pool. Many contracts will be issued at premiums less than the maximum and not pooled. In this way, the residents of Ontario will gain the advantages of competition among all the carriers to give them the best service at the lowest possible cost.

20. In the case of pooled contracts, the carrier concerned will credit to the pool the maximum premium, less an agreed expense allowance. Each year the pool will determine the amount of the losses (i.e. the amount by which the incurred claims and the pools' operating expenses exceed the income received) and these losses will be shared among the participating carriers in proportion to the number of residents between the ages of 20 and 64 they insure for any form of medical services insurance as defined in Bill 163, and have not pooled.

21. It is expected that the exact sharing formula will be worked out in detail by MCI and will be designed to give due recognition to those carriers that presently are insuring a larger proportion of the aged than the average for all carriers in the province.

22. It is recognized that this type of pooling arrangement, although necessary, will introduce some difficulties for all carriers, including those which operate community-rated plans. For example, the latter do not operate as other carriers do

on the basis of underwriting each individual risk based on the health of the insured as determined from the statements made in his application. Such plans would normally accept without any evidence of insurability applications made by persons entitled to apply for benefits. For this reason, we suggest that the pooling arrangement include the right of any carrier to apply for exemption from the pool in the manner outlined below.

23. The pooling arrangement would involve two pools: (1) for persons under the age of 65 years and (2) for persons 65 and over. Every carrier in the province, including the insurance companies, the doctor-sponsored plans, the cooperatives and the self-insurers would be required, under the regulations of MCI, to join the pooling arrangement. Any such carrier, however, could apply to MCI for exemption from pool (1) provided it could satisfy the Directors of MCI that it was fulfilling the objectives that the pooling arrangement was intended to achieve. The right to apply for exemption would not apply to pool (2). If a carrier were exempted from participation in pool (1) it would not participate in the sharing of the losses arising under that pool, but would participate in the sharing of the

losses under pool (2). This is essentially the arrangement which has been adopted in the Province of Alberta.

24. In operating the pooling arrangement it would be necessary to set down certain rules of procedure and these rules would be developed by the Board of MCI. The precise formula for assessing the losses among the various carriers would also be determined by MCI and this formula could be changed from time to time as experience indicated was necessary.

25. Although Bill 163, in its present form, does not at any point mention that such a pooling arrangement is necessary it is important to record here that because of the possible financial hazards involved in the Plan, the members of CHIA will be able to participate only if there is a pooling arrangement. Such an arrangement will guarantee that carriers will participate vigorously in the promotion of the program.

26. Accordingly we have included in Appendix II suggested provisions for the legislation relating to pooling.

SECTION C

SUGGESTIONS REGARDING THE INCLUSION OF A PLAN WITH CO-INSURANCE AND DEDUCTIBLES IN PLACE OF THE STANDARD IN-HOSPITAL CONTRACT

27. The Association has given careful consideration to the intention in Bill 163 that there be a standard medical services insurance contract with benefits for services both in and out of hospital, and that there be also a standard in-hospital medical services insurance contract with benefits limited to services for admitted hospital bed patients.

28. We believe that the standard medical services insurance contract as outlined in Schedule A to Bill 163 fulfils the objectives of the government as outlined by the Minister of Health. This contract covers individual and family medical care expenses on a broad base; it is universally available regardless of age, health, or occupation; it is guaranteed renewable; and there is to be a maximum premium fixed for the contract.

29. While in this submission we set out some recommendations regarding details of the contract, we are here stating our agreement in principle that this contract can fulfil the government's objectives.

30. However, we have some definite reservations about the suitability of the standard in-hospital medical services contract, and suggest that consideration be given to dropping

this and replacing it with a contract providing the same benefits as outlined in Schedule A for the standard medical services insurance contract, but with a co-insurance and deductible arrangement.

31. Our Association therefore recommends that the benefits in Schedule B to Bill 163 be identical to those in Schedule A, and that the contract set out in Schedule B be a standard medical services co-insurance contract subject to a deductible of $25 per person per calendar year, with a maximum family deductible of $50 for each calendar year dating from January 1, and that it be subject to a 20 percent co-insurance provision. This contract would be available only to those who do not come within the subsidized category.

32. We believe that such a contract, as compared with the standard in-hospital contract, would cover a wider range of medical expenses and thus provide better coverage for the insured. It would avoid many of the disadvantages of the in-hospital contract and so would be a more suitable alternative to the standard medical services insurance contract, but at a lower premium (about one-third less than the premium for the standard medical services insurance contract).

33. The deductible and co-insurance arrangement in health insurance contracts has developed as part of the insurance companies' program of providing ever broader coverage to

increasing numbers of people. Under this arrangement, the premium is kept down as the insured pays small medical costs (where the cost of administration is disproportionately high) until the deductible is satisfied. Experience has indicated the value of an arrangement where the insured shares in the cost of each medical service. Such an arrangement operates in favour of the insured by keeping his premiums at a minimum, and of the medical profession and the hospitals as it tends to restrict unreasonable and minor demands on their services. These advantages have commended themselves to the many who now hold such contracts and this arrangement has become a common one in this field.

34. Our experience in administering in-hospital benefits indicates that, by themselves as proposed under the standard in-hospital contract, they pose serious problems in doctor-patient relationships, in public relations with patients, in hospital utilization and bed availability and in administration. Some disadvantages of the standard in-hospital contract by itself are:

(1) It does not cover the situation of the aged and those with chronic conditions whose situation requires considerable medical care in the home or at the doctor's office.

(2) It does not meet the situation, often encountered, where large medical expenses arise outside the hospital.

(3) There is a tendency where there is in-hospital coverage alone, to delay release of patients to either a nursing home or to their own homes.

(4) Where there is in-hospital coverage alone, there is a tendency for patients to prefer treatment in hospital regardless of the medical need for hospitalization. This creates difficulties between patients and doctors and thus puts pressure on hospital accommodation.

35. We believe that the suggested standard medical services co-insurance contract would prove to be a better alternative than the standard in-hospital contract and be more satisfactory to the insured, the government and all concerned.

S E C T I O N D

SUGGESTIONS REGARDING THE APPLICATION OF A GOVERNMENT SUBSIDY AND THE IDENTIFICATION OF THE RESIDENTS ELIGIBLE FOR IT

36. Dr. Dymond has said: "... the government should accept the responsibility for those who cannot make provision for their own medical health care." The amount of government assistance and the identification of the residents eligible to receive it are, of course, matters for political and Treasury decisions. We realize that in the following section we touch upon some areas which are outside the scope of our immediate responsibility as carriers. However, in our appearances before the Royal Commission on Health Services last year, we were specifically requested to present our opinions on the question of subsidies and their application. It was with the thought that this Enquiry might also be interested in our views on this important subject that they are included in this section.

37. In an earlier section of this submission we expressed our confidence that the voluntary carriers in Ontario, using the basic principles enunciated by the government in the Ontario Bill to enact the Medical Services Insurance Act (Bill 163), can make available a satisfactory standard of medical services insurance to every resident of the province. Moreover, this insurance would be available to all those

generally considered to be in the high-cost categories by reason of their age, condition of health and nature of occupation. There would be maximum limits on the premiums chargeable by all carriers, and below these limits the premiums would vary from carrier to carrier, thus simultaneously setting a maximum ceiling on premiums and bringing the regulation of the market place and the forces of competition to bear in favour of the insured. Assuming the necessity of government assistance to those unable to provide for their own medical services insurance, three important factors must be considered. These are:

(1) The identification of the residents who require subsidization.

(2) The principle or method of applying the subsidy.

(3) The administrative machinery necessary to handle the subsidy most efficiently.

38. To be successful, the principles and practice of applying the government subsidy should, in our opinion, measure up to the following criteria:

(1) They must be compatible with the principles established by the government.

(2) They must be acceptable to the medical profession whose vital task it will be to provide the services paid for.

(3) They must be clear, simple and easily understood by the public.

(4) They should, wherever possible, make use of existing administrative machinery for the sake of both economy and simplicity.

39. The subsidy itself should, in our opinion, be:

(1) focussed on that segment of the population which needs it most and be as high as Treasury funds will permit;

(2) adequate to bring coverage within the reach of those eligible for it.

40. We believe that the formula suggested in this section satisfies these requirements.

41. There are two categories of residents mentioned in Bill 163 as being eligible for government assistance--first, those in needy circumstances and receiving benefits under present government welfare Acts and, second, others who are in needy circumstances but who are not receiving welfare benefits. The first group includes those whose economic circumstances are such that they require assistance in providing such basic necessities of life as food, clothing and shelter. Clearly, if they are to have medical services insurance, members of this group must have the entire cost of that insurance absorbed by the government. At the present time we understand that between 225,000 and 250,000 citizens of Ontario are enrolled under the welfare plan operated by the Ontario Department of Public Welfare and administered by the Ontario Medical Association (called the "Ontario Medical Welfare Plan"). These are the people referred to in section 3(a) and in Schedule C

of Bill 163. The present benefits under the Ontario Medical Welfare Plan, however, are somewhat more limited than those proposed under the standard medical services insurance contract. If the government desires and the medical profession concurs, benefits identical with those provided by the standard medical services insurance contract could be made available to those persons now under the Ontario Medical Welfare Plan. Such an arrangement would be outside the operation of the program in Bill 163 and would presumably be operated under an agreement between the government and the medical profession.

42. With the second group for whom assistance is contemplated (referred to in section 3(b) in Bill 163) a somewhat more difficult problem arises. People in this category are in needy circumstances but are not in receipt of assistance under any of the Acts in Schedule C. The Minister is authorized by the Bill to provide partial assistance for this group. However, the group is not further delineated. The subsidy arrangement for this group should be designed in such a way that it adequately covers those in the area of greatest need. Moreover, the deter-

mination of eligibility for subsidy within this marginal income group must be practical in the sense that it is simple enough to be readily understood and economically administered and, at the same time, in the sense that it provides a proper subsidy where a subsidy is required, so that medical services insurance is available to all in fact as well as in theory. The type of subsidy suggested in this section of our submission is not designed to make use of public funds to subsidize the purchase of medical services insurance for those who are financially able to provide it for themselves. It is rather an incentive subsidy designed to assist those who want to help themselves as much as possible but who cannot, under present conditions, afford to pay the entire premium required for this coverage.

43. Lengthy and searching study and consideration of the various avenues of making this subsidy readily available to all who require it, has led us to propose that the eligibility for subsidy be related to the personal income exemption levels as set out in the Income Tax Act.

44. Recognizing the widespread public antipathy towards various forms of means tests to determine eligibility for government assistance, our Association has selected instead an income test. Inasmuch as some 80 percent of the population is already income tested through existing legislation, the identification of the marginal income group by this means would not involve the application of a means test and the individual's eligibility

for assistance could quickly and easily be determined by making use of the machinery which is already in existence. The procedure to which the applicant for subsidy must subject himself is not any more onerous than that required of tax-paying Canadians.

45. We would therefore suggest that the dividing line between the self-sufficient and those to be assisted by government should be set at the limit at which income exceeds the personal exemptions set out in the Income Tax Act.

46. There are, we believe, a number of important advantages in a definition of eligibility related to these personal income exemption levels. It is surely logical to assume that a citizen considered by government to be in such an economic position that he should pay an income tax could not, at the same time, be considered so needy as to require a provincial subsidy to pay a small medical services insurance premium. By the same token, a person whose income is such that he is not required to pay income tax could reasonably be assumed to require some degree of subsidy to pay for his medical services insurance premium.

47. A further advantage of selecting this method of defining eligibility for subsidy is the fact that in determining the individual's personal income tax exemptions, such variables as his marital status, number of dependants, age, etc. are automatically taken into account.

48. We suggest therefore, for consideration, that those persons whose incomes are less than 100% of the personal exemptions mentioned and who are not receiving

assistance under any of the Acts mentioned in Schedule C, and thus are not getting their medical care provided under the Ontario Medical Welfare Plan, should be entitled to government assistance. We suggest that these persons should be given a fixed dollar subsidy in an amount which would pay a substantial portion of their premium. Such a subsidy would apply only on the standard medical services insurance contract as outlined in Schedule A. The amount of subsidy would, of course, differ according to the status of the applicant. A subsidy for an entire family would be greater than that for a couple, and both would be greater than that for a single person.

49. We wish to establish clearly, as a point of principle, that we, as insurers, do not need or want a government subsidy. We would like it clearly understood that the subsidies would be paid by the government on behalf of those residents who require them, and that they are not subsidies for the benefit of the insurers. We anticipate that this point of view is shared by the government as well.

50. Among the advantages of a fixed dollar subsidy, which was the method decided upon in Alberta, are:

(1) It is the simplest method to explain to the public.

(2) It is the simplest and, hence, the most economical to administer.

(3) It is simple to change.

(4) It permits a high degree of accuracy in the calculation of the total amount of subsidy for which the government must budget. Similarly the cost of changes in the amount of subsidy can readily be calculated once the number of people in the marginal income category has been determined.

(5) The fixed dollar subsidy method in no way interferes with the doctor's practice of medicine.

51. With this in mind, there are a number of ways the administrative machinery could be designed. Here, as before, simplicity is of the essence, both for the insured and the government. For the former it is essential that the routine be simple in order to make it easy and attractive to become insured. For the latter, simplicity and ease of operation spell economy.

52. We suggest, therefore, that the application for subsidy and the application for medical services insurance be completed at the same time.

53. Applicants for subsidy could take the following steps to establish their eligibility and apply for coverage under the

Plan:

(1) The applicant would complete a statement in which he certified that his income for the preceding calendar year was less than 100 percent of his personal exemptions as set out in the Income Tax Act. He would include with this statement suitable information to establish his residence qualifications. This would constitute the application for subsidy. (There would, of course, be some exceptions where the subsidy would not be paid, such as in cases where there is more than one income in the family totalling more than the personal income tax exemptions of the family head or where the applicant is a Treaty Indian, etc.).

(2) The applicant would send the information detailed in (1) to the carrier of his choice, accompanying the application with the net payment for the initial premium.

54. On the basis of this application for subsidized coverage, the carrier could:

(1) issue the contract to the applicant, and

(2) send the subsidy application to the appropriate government Department. (Under such an arrangement

the government would protect the carrier which acted upon the subsidy in good faith and would hold it harmless in the event of a fraudulent or erroneous statement on subsidy being subsequently uncovered.)

55. The government could then forward to the carrier the proper subsidy on behalf of the eligible applicant on a monthly, quarterly, semi-annual or annual basis, depending upon the mode of premium payment provided by the contract. The carrier could collect any balance owing on the premium over and above the subsidized portion in accordance with the mode of payment provided.

56. We would anticipate that the duration of the subsidy authorization would be for 12 months from the effective date of the policy. Presumably the government would wish to retain the right to review each subsidy annually. The carriers could assume the responsibility of advising their policyholders to seek this renewal of subsidy privilege.

57. Our comments on the administrative machinery are, of course, simply an outline which we feel would be effective for all concerned. We recognize that they will require much more detailed working out with the government and the medical profession at a later time.

SECTION E

FURTHER SUGGESTED AMENDMENTS TO PROVISIONS OF BILL 163

58. As previously indicated in the "Summary and Recommendations", our Association has made a detailed study of Bill 163 and desires to submit for consideration of the Enquiry certain amendments to cover the recommendations set forth in this submission.

59. Accordingly, in the attached Appendix II there are reproduced on the left-hand pages (1 to 16, incl.) the actual provisions of Bill 163. On the opposite, right-hand pages (1a to 16a) are set out CHIA's suggested amendments to the Bill.

60. As a matter of convenience in reviewing CHIA's suggestions, completely new proposed provisions and those involving complete revisions of parts of Bill 163 have been sidelined; other suggested changes are underlined.

61. In the interest of clarity, and to enable easy comparision of the existing and proposed provisions, no attempt has been made in Appendix II to explain or justify the suggested amendments. We shall, of course, be happy to explain the reasons for the proposed changes, either at the hearing at which this submission is presented or at any other time desired by the Enquiry.

62. It should again be noted that Appendix II does not contain provisions to establish the committees and other bodies constituting

the suggested organizational structure (see Section A). We will of course be glad to suggest appropriate wordings if asked to do so.

Toronto, Ontario,
November 14, 1963.

APPENDIX I

THE CHIA -- WHAT IT IS

On June 11, 1959, an Organization Meeting was held in Toronto to establish the Canadian Health Insurance Association.

Formation of the Association had been recommended by the Joint Committee on Health Insurance, established in 1953 by the All Canada Insurance Federation (representing casualty insurance companies) and The Canadian Life Insurance Officers Association (representing life insurance companies). The Joint Committee on Health Insurance was disbanded on the formation of CHIA with its broader concept and functions.

Membership in CHIA is made up of 116 insurance companies, and this membership includes the major companies doing personal accident and sickness business in Canada.

Together these member companies account for more than 96 percent of all health insurance in Canada, both group and individual.

Annual premiums for this class of business paid to member companies are approximately $187,000,000.

Membership embraces the following three distinct types of insurance companies:

1. Members which concentrate solely upon health insurance through sale of either individual or group contracts.
2. Life insurance companies which offer in addition to life insurance, accident and sickness coverage, either through group contracts only, or through group and individual contracts.
3. Casualty companies which offer this type of coverage in addition to other general lines of insurance.

A complete list of all CHIA members, as of November 14, 1963, appears on pages 6 to 8 of this Appendix.

A list of the current Executive Committee members also appears at page 9 of this Appendix.

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EXTRACTS FROM CONSTITUTION OF THE CANADIAN HEALTH INSURANCE ASSOCIATION

Article I

NAME

This Association shall be a voluntary and non-profit association of insurance companies transacting personal accident and sickness insurance and shall be known as the "Canadian Health Insurance Association".

Article II

PURPOSE

The purpose of the Association shall be to foster the development of voluntary insurance providing sound protection against loss of income and financial burdens resulting from accident and sickness.

Article III

FUNCTIONS

The functions of the Association shall be:

1. To coordinate and express the views of its member companies as to matters affecting accident and sickness insurance.
2. To encourage further improvement in and extension of the coverage

and benefits of personal accident and sickness insurance.

3. To establish standards of conduct in the accident and sickness insurance business.

4. To promote understanding of and to maintain public confidence in voluntary accident and sickness insurance.

5. To strengthen relationships with persons and organizations providing health care.

6. To engage in such other activities as will further the purpose of the Association.

The Association shall not, in any way, bind a member company in the use of premium rates, policy forms, coverages, or classification of risks or limit a member company's freedom of action in the conduct of its business. No member company shall be considered individually committed by any action of the Association or its committees, except with respect to such matters as may be related directly to the administrative business of the Association.

Article IV

MEMBERSHIP

Any company or organization licensed to transact personal accident and sickness insurance in Canada may, upon recommendation of the Membership Committee, be admitted to membership upon a three-quarters vote of member companies represented at a meeting of the Association or by a unanimous vote of those present at a meeting of the Executive Committee.

Two or more member companies affiliated with each other through common control shall be treated for all purposes as a single member company and shall have one vote.

Membership in the Association may be terminated (a) by failure to pay fees or assessments within ninety days after due date, (b) as at the commencement of the next ensuing fiscal year, upon giving ninety days written notice of withdrawal to the President, Executive Committee or Managing Director of the Association, and (c) by unanimous vote of the Executive Committee if, after consideration of a report from a special investigating committee, it is of the opinion that a member company has been guilty of conduct prejudicial to the accident and sickness business and the Association.

Article V

MEETINGS

An annual meeting of the Association shall be held at a time and place to be determined by the Executive Committee.

Special meetings of the Association may be called at any time by the President or the Executive Committee, and shall be so called at the written request of seven member companies of the Association. Notice of the annual or any special meeting of the Association, stating the purpose of the meeting, shall be sent to member companies at least ten days prior to the date of the meeting.

At all meetings of the Association one-fifth of the member companies representing not less than 50% of the accident and sickness premium income in Canada of all member companies, shall constitute a quorum. The right to vote shall be limited to the chief executive officer of each member company or to his authorized designee.

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CODE OF ETHICAL STANDARDS

To encourage maintenance of the highest standards of protection and service, and to sustain public confidence in the business of voluntary

accident and sickness insurance, the Executive Committee of CHIA in September, 1960 recommended to all Association members the following Code of Ethical Standards:

1. To offer only insurance providing effective and real protection against such loss as the policy is designed to cover.
2. To write its policies in clear and direct language without unreasonable restrictions and limitations.
3. To advertise its policies in such manner that the public can readily understand the protection offered, and not use advertising which has tendency or capacity to mislead or deceive.
4. To select, train, and supervise personnel of integrity in a manner which will assure intelligent, honest, courteous sales and service.
5. To engage only in sales methods, promotional practices and other transactions which give primary consideration to the needs, interest, and continued satisfaction of the persons insured.
6. To endeavor to establish the insurability of persons at the time of application in every instance where such insurability is a factor in the issuance or continuance of the insurance or in the liability of the insurer.
7. To pay all just claims fairly, courteously, and promptly, with a minimum of requirements.
8. To continue research and experimentation in order to meet the changing needs of the public.
9. To engage in keen, fair competition so the public may obtain the protection it needs at a reasonable price.

CANADIAN HEALTH INSURANCE ASSOCIATION

MEMBER COMPANIES

AS AT NOVEMBER 14, 1963

Aetna Companies:
  Aetna Life Insurance Company, and
  The Excelsior Life Insurance Company
Alliance Mutual Life Insurance Company
Allstate Insurance Company

British Pacific Life Insurance Company
Business Men's Assurance Company of America

Canada Health & Accident Assurance Corporation
The Canada Life Assurance Company
Canadian General Group:
  Canadian General Insurance Company, and
  Toronto General Insurance Company
Canadian Group:
  Canadian Indemnity Company
Canadian Premier Life Insurance Company
Canadian Reinsurance Company
Combined Insurance Company of America
Confederation Life Association
Connecticut General Life Insurance Company
Continental Assurance Company
Continental Casualty Group:
  Continental Casualty Company, and
  Transportation Insurance Company
The Crown Life Insurance Company

Dominion Group:
  The Dominion Insurance Corporation, and
  Firemen's Insurance Company
The Dominion Life Assurance Company
Dominion of Canada General Group:
  Casualty Company of Canada, and
  The Dominion of Canada General Insurance Company

Eagle Star Group:
  British Northwestern Insurance Company
The Empire Life Insurance Company
Employers Reinsurance Corporation
The Equitable Life Assurance Society of the U.S.
The Equitable Life Insurance Company of Canada

Federal Life and Casualty Company
Federated Mutual Implement and Hardware Insurance Company

Global Life Insurance Company
Great American Group:
  American National Fire Insurance Company, and
  Great American Insurance Company
The Great-West Life Assurance Company

(continued)

CHIA Member Companies
- 2 -

Guardian-Caledonian Group:
Caledonian-Canadian Insurance Company,
Caledonian Insurance Company,
Guardian Assurance Company Limited,
The Guardian Insurance Company of Canada, and
The Insurance Corporation of Ireland Limited

The Halifax Insurance Company

The Imperial Life Assurance Company of Canada
Industrial Life Insurance Company

John Hancock Mutual Life Insurance Company

Legal & General Group:
Legal & General Assurance Society
The London & Lancashire Group:
Law Union & Rock Insurance Company Limited, and
The London & Lancashire Guarantee & Accident Co. of Canada
London Assurance Group:
Citadel Insurance Company,
Guildhall Insurance Company, and
The London Assurance
The London Life Insurance Company
Loyal Protective Life Insurance Company

Massachusetts Mutual Life Insurance Company
The Mercantile and General Reinsurance Company of Canada Limited
Metropolitan Life Insurance Company
The Ministers Life and Casualty Union
The Mutual Life Assurance Company of Canada
The Mutual Life Insurance Company of New York
Mutual of Omaha Insurance Company

The National Life Assurance Company of Canada
New York Life Insurance Company
North America Group:
Insurance Company of North America
North American Life and Casualty Company
North American Life Assurance Company
The Northern & Employers Group:
The Employers' Liability Assurance Corporation Limited,
London & Scottish Assurance Corporation Limited,
The Merchants Marine Insurance Company Limited,
The Northern Assurance Company Limited,
Scottish Metropolitan Assurance Company Limited, and
The World Marine & General Insurance Company Limited

Occidental Life Insurance Company of California

The Paul Revere Life Insurance Company
Pearl Assurance Company Limited

(continued)

CHIA Member Companies
- 3 -

Phoenix of London Group:
The Acadia Insurance Company,
London Guarantee & Accident Company Limited, and
Phoenix Assurance Company Limited
Pitts Insurance Company Limited
The Provident Assurance Company
Provident Life and Accident Insurance Company
The Prudential Insurance Company of America
Prudential of England Group:
The Prudential Assurance Company Limited

Royal Exchange-Atlas Group:
Atlas Assurance Company Limited,
Car and General Insurance Corporation Limited,
Essex & Suffolk Insurance Company Limited,
Motor Union Insurance Co. Limited,
Royal Exchange Assurance, and
United Canada Insurance Company

St. Paul Fire & Marine Group:
St. Paul Fire & Marine Insurance Company
Seaboard Life Insurance Company
Sterling Offices Group:
The Great Lakes Reinsurance Company,
Munich Reinsurance Co. Limited,
The Reinsurance Corporation Limited,
Skandinavia Insurance Company Limited,
Union Reinsurance Company,
Universal Reinsurance Company Limited, and
Victory Insurance Company
Sun & Alliance Insurance Groups:
Alliance Assurance Company Limited,
Imperial Insurance Office,
London and County Insurance Company Ltd.,
Patriotic Assurance Company Ltd.,
Planet Assurance Company Ltd., and
Sun Insurance Office Ltd.
Sun Life Assurance Company of Canada

The Travelers Insurance Company

Union Mutual Life Insurance Company
Union of Canton Group:
Union Insurance Society of Canton
United States Fidelity Group:
Fidelity Insurance Company of Canada, and
United States Fidelity & Guaranty Co.

The Western-British America Assurance Group:
The British America Assurance Company,
The British Canadian Insurance Company,
The British Empire Assurance Company,
The Imperial Guarantee & Accident Insurance Company of Canada, and
The Western Assurance Company

Yorkshire Group:
Yorkshire Insurance Company Limited

Zurich Insurance Company

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EXECUTIVE COMMITTEE 1963-64

President: Mr. G. R. Berry
Vice-President and General Manager,
Metropolitan Life Insurance Company (Ottawa)

Vice-President: Mr. R. N. Mackintosh
Manager, Group Division,
Zurich Insurance Company (Toronto)

Honorary Treasurer: Mr. John Holden
Assistant Manager for Canada,
London & Lancashire Group (Toronto)

Past President: Mr. D. E. Kilgour
President,
The Great-West Life Assurance Company (Winnipeg)

Messrs. D. G. Andress
Casualty Superintendent,
The Northern & Employers Group (Montreal)

J. C. Davey
Vice-President and General Manager,
The Paul Revere Life Insurance Company (Hamilton)

S. Gwyn Dulaney
Second Vice-President,
The Travelers Insurance Company (Hartford)

D. M. Ellis
Vice-President and Senior Actuary,
The Canada Life Assurance Company (Toronto)

J. K. Macdonald
President,
Confederation Life Association (Toronto)

Hugh McLeod
Vice-President, Group,
Sun Life Assurance Company of Canada (Montreal)

A. Ross Poyntz
President,
The Imperial Life Assurance Company of Canada (Toronto)

Earl Putnam
Chairman of the Board,
Canada Health & Accident Assurance Corporation (Waterloo)

R. R. Story
Canadian General Manager,
Continental Casualty Company (Toronto)

F. A. Walton
Executive Vice-President,
Mutual of Omaha Insurance Company (Toronto)

G. N. Watson
Group Vice-President,
The Crown Life Insurance Company (Toronto)

(1 vacancy)

November 14, 1963.

APPENDIX II

DETAILS OF CERTAIN AMENDMENTS TO THE PROVISIONS OF BILL 163 SUGGESTED BY CHIA

Note: Actual provisions of Bill 163 reproduced on left-hand pages 1 to 16 incl.

CHIA suggested amendments indicated on right-hand pages 1a to 16a incl.

Sidelining indicates entirely new suggested provisions or complete revisions of parts of Bill 163.

Underlining indicates other suggested amendments.

PROVISIONS OF BILL AS INTRODUCED

BILL 163 **1962-63**

An Act respecting Medical Services Insurance

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

1. In this Act,

(*a*) "benefit" means a payment made to a covered person for medical or surgical care or services or the performance of such care or services for a covered person under a medical services insurance contract;

(*b*) "carrier" means a person, firm, group, association, society, union, agency or corporation that sells or provides or offers to sell or provide medical services insurance;

(*c*) "covered person" means a person who is covered by medical services insurance;

(*d*) "dependant" means a resident who is,

(i) the spouse of the head of a family,

(ii) any unmarried child under the age of nineteen years who is dependent or substantially dependent for maintenance upon the head of a family, or

(iii) any son or daughter who by reason of mental or physical infirmity is dependent or substantially dependent for maintenance upon the head of a family, and who was, prior to the age of nineteen, dependent or substantially dependent for maintenance upon the head of a family;

CHIA SUGGESTIONS FOR AMENDMENTS TO BILL 163

BILL 163 **1962-63**

An Act respecting Medical Services Insurance

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

1. In this Act,

(a) "benefit" means a payment made to or on behalf of a covered person for medical or surgical care or services or the performance of such care or services for a covered person under a medical services ~~insurance~~ contract;

(*b*) "carrier" means a person, firm, group, association, society, union, agency or corporation that sells or provides or offers to sell or provide medical services insurance;

(*c*) "covered person" means a person who is covered by medical services insurance;

(d) "dependant" means a resident who is,

(i) the spouse of a head of a family, or

(ii) a child of the head of a family who is dependent for support upon the head of the family and who is,

(A) under the age of nineteen years and unmarried, or

(B) nineteen years of age or over, mentally or physically infirm, and dependent for support upon the head of the family or upon the spouse of the head of the family before his nineteenth birthday, but does not include the spouse of any such child;

(*e*) "guaranteed renewable" means the right conferred upon a covered person, in the absence of misrepresentation or non-payment of subscription, to continue a medical services insurance contract in force from the date of issue until the carrier is no longer licensed under this Act;

(*f*) "head of a family" means the member of the family upon whom the family is principally dependent for maintenance;

(*g*) "hospital" means a hospital that is approved for the purposes of the plan of hospital care insurance under *The Hospital Services Commission Act*;

(*h*) "Medical Carriers Incorporated" means the non-profit corporation, incorporated pursuant to Part III of *The Corporations Act*, whose membership is composed of the carriers licensed under this Act;

(*i*) "medical services insurance" means a contract, agreement, scheme, fund or arrangement whereby a resident is covered for medical or surgical care or services or the cost or a portion thereof when rendered to such resident and his dependants by or under the direction of a physician, but does not include the limited and incidental insurance against medical and surgical expenses provided in conjunction with motor vehicle liability, employer's liability, public liability, and workmen's compensation insurance policies;

(*j*) "Minister" means the member of the Executive Council to whom the administration of this Act is assigned by the Lieutenant Governor in Council;

(*k*) "open enrolment period" means a period that is from time to time designated as such by Medical Carriers Incorporated;

(*l*) "physician" means a medical practitioner registered as such under *The Medical Act* or under the comparable legislation of any jurisdiction outside Ontario in which medical or surgical care or services are rendered to a resident;

(e) "guaranteed renewable" means the right conferred upon a contractholder for so long as he is a resident to renew a standard medical services insurance contract or a standard medical services co-insurance contract subject only to the provisions of this Act and the terms, conditions and maximum subscription in force for such contract at the date of renewal;

(*f*) "head of a family" means the member of the family upon whom the family is principally dependent for maintenance;

(*g*) "hospital" means a hospital that is approved for the purposes of the plan of hospital care insurance under *The Hospital Services Commission Act*;

(*h*) "Medical Carriers Incorporated" means the non-profit corporation, incorporated pursuant to Part III of *The Corporations Act*, whose membership is composed of the carriers licensed under this Act;

(i) "medical services insurance" means a contract, agreement, scheme, fund or arrangement whereby a resident is covered for medical or surgical care or services or the cost or a portion thereof when rendered to such resident and his dependants by or under the direction of a physician, but does not include any limited or incidental coverage arising out of or provided in conjunction with a contract of accident, motor vehicle liability, employer's liability, public liability or workmen's compensation insurance;

(*j*) "Minister" means the member of the Executive Council to whom the administration of this Act is assigned by the Lieutenant Governor in Council;

(*k*) "open enrolment period" means a period that is from time to time designated as such by Medical Carriers Incorporated;

(*l*) "physician" means a medical practitioner registered as such under *The Medical Act* or under the comparable legislation of any jurisdiction outside Ontario in which medical or surgical care or services are rendered to a resident;

(*m*) "regulations" means the regulations made under this Act;

(*n*) "resident" means an individual who is legally entitled to remain in Canada, who makes his home and ordinarily resides in Ontario and who has resided in

Ontario for a continuous period of at least ninety days immediately preceding the date on which the determination is made;

(*o*) "standard in-hospital medical services insurance contract" means a contract that provides the benefits set forth in Schedule B;

(*p*) "standard medical services insurance contract" means a contract that provides the benefits set forth in Schedule A;

(*q*) "subscription" means the premium, fee or other sum of money payable for a standard medical services insurance contract or a standard in-hospital medical services insurance contract, and includes all sums of money payable from time to time to maintain such a contract in force;

(*r*) "Superintendent" means the Superintendent of Insurance for Ontario.

2. Medical services insurance is available in accordance with this Act and the regulations to every resident and his dependants who are residents, without regard to age, physical or mental infirmity, financial means or occupation.

3. The Minister may, in accordance with the regulations,

(*a*) purchase standard medical services insurance contracts for such classes of persons as are set forth in Schedule C and who are in needy circumstances; and

(*b*) contribute to the purchase of standard medical services insurance contracts for such other classes of persons as are set forth in the regulations and who are in needy circumstances.

(*m*) "regulations" means the regulations made under this Act;

(*n*) "resident" means an individual who is legally entitled to remain in Canada, who makes his home and ordinarily resides in Ontario and who has resided in

Ontario for a continuous period of at least ninety days immediately preceding the date on which the determination is made;

(o) "standard medical services co-insurance contract" means a contract that provides the benefits set forth in Schedule B;

(*p*) "standard medical services insurance contract" means a contract that provides the benefits set forth in Schedule A;

(q) "subscription" means the premium, fee or other sum of money payable for a standard medical services insurance contract or a standard medical services co-insurance contract, and includes all sums of money payable from time to time to maintain such a contract in force;

(*r*) "Superintendent" means the Superintendent of Insurance for Ontario.

2. The standard medical services insurance contract and the standard medical services co-insurance contract are available in accordance with this Act and the regulations to all residents without regard to age, physical or mental infirmity, financial means or occupation.

3. The Minister may, in accordance with the regulations,

(*a*) purchase standard medical services insurance contracts for such classes of persons as are set forth in Schedule C and who are in needy circumstances; and

(*b*) contribute to the purchase of standard medical services insurance contracts for such other classes of persons as are set forth in the regulations and who are in needy circumstances.

4. A local municipality may, on behalf of residents residing therein,

(*a*) who receive municipal unemployment or other assistance; or

(*b*) who are referred to under section 54 of *The Public Health Act*,

purchase or contribute to the purchase of standard medical services insurance contracts or standard in-hospital medical services insurance contracts for such residents.

5. No carrier shall sell or provide or offer to sell or provide any other form of medical services insurance unless,

(*a*) it offers for sale and issues,

(i) guaranteed renewable standard medical services insurance contracts, and

(ii) guaranteed renewable standard in-hospital medical services insurance contracts,

to residents who are not dependants, other than a spouse, and who apply and pay the subscription therefor; and

(*b*) it is a member in good standing of Medical Carriers Incorporated.

6. Nothing in this Act prevents a carrier from providing benefits under contracts of medical services insurance greater than those set forth in Schedules A and B.

7.—(1) Every carrier shall obtain from the Minister and hold a licence under this Act.

(2) Every carrier that carries on business as such without a licence under this Act is guilty of an offence and on summary conviction is liable to a fine of not more than $1,000.

4. A local municipality may, on behalf of residents residing therein,

(*a*) who receive municipal unemployment or other assistance; or

(*b*) who are referred to under section 54 of *The Public Health Act*,

purchase or contribute to the purchase of standard medical services insurance contracts for such residents.

5. No carrier shall sell or provide or offer to sell or provide any form of medical services insurance unless it is a member in good standing of Medical Carriers Incorporated and,

(a) it offers for sale and issues guaranteed renewable standard medical services insurance contracts or guaranteed renewable standard medical services co-insurance contracts to all residents who are not dependants, other than the dependent spouse of a resident, and who apply and pay the subscription therefor; and

(b) it offers for sale and issues guaranteed renewable standard medical services insurance contracts as may be required pursuant to the provisions of sections 3 and 4 hereof,

unless such carrier is specifically exempted by Medical Carriers Incorporated.

6. Nothing in this Act prevents a carrier from providing benefits under contracts of medical services insurance other than those set forth in Schedules A and B.

7.—(1) Every carrier shall obtain from the Minister and hold a licence under this Act.

(2) Every carrier that carries on business as such without a licence under this Act is guilty of an offence and on summary conviction is liable to a fine of not more than $1,000.

8.—(1) The members of Medical Carriers Incorporated shall be assessed annually for the moneys required for the operation of the corporation.

(2) The proportion of the total assessment to be levied in any year to be borne by each member shall be determined in an equitable manner by the board of directors of the corporation and confirmed by at least two-thirds of the votes cast by the members present in person or represented by proxy and entitled to vote at any annual or general meeting of the members of the corporation.

(3) The number of votes to be cast by or on behalf of any member shall be based upon the proportion of the number of persons covered by the member under contracts of medical services insurance in relation to the persons so covered by all members, and the by-laws of the corporation may provide the necessary regulations with respect thereto.

7a. There shall be established a non-profit corporation to be known as Medical Carriers Incorporated, the principal objects of which shall be:

(a) to consider and set maximum subscription rates for standard medical services insurance contracts and standard medical services co-insurance contracts issued on an individual or family basis;

(b) to set an initial open enrolment period and such enrolment procedures as it shall deem advisable;

(c) to prescribe and enforce qualifications for membership in the corporation;

(d) to administer pooling arrangements which shall be mandatory on all members unless exempt under the regulations of the corporation;

(e) to deal with such other matters as relate to the technical aspects of medical services insurance.

8.--(1) Subject to the provisions of section 5, the following carriers shall be eligible for membership in Medical Carriers Incorporated:

(a) Carriers licensed to undertake the business of accident and sickness insurance under The Insurance Act of Ontario;

(b) Associated Medical Services Incorporated, Physicians Services Incorporated and Windsor Medical Services Inc.;

(c) Any carriers not included in clause a or b of this subsection.

(2) Each class of carrier described in subsection 1 admitted to membership in Medical Carriers Incorporated shall be entitled to be represented at all annual general meetings and special general meetings of members as follows:

(a) The class of carrier described in clause a of subsection 1 shall be represented by five persons, each of whom shall be entitled to attend and cast one vote, either in person or by proxy, on each question arising at any annual general or special general meeting of members;

(b) The class of carrier described in clause b of subsection 1 shall be represented by five persons, each of whom shall be entitled to attend and cast one vote, either in person or by proxy, on each question arising at any annual general or special general meeting of members;

(c) The class of carrier described in clause c of subsection 1 shall be represented by two persons, each of whom shall be entitled to attend and cast one vote, either in person or by proxy, on each question arising at any annual general or special general meeting of members.

(3)The affairs of Medical Carriers Incorporated shall be managed by a board of seven directors and, notwithstanding the provisions of subsection 2 of section 8,

(a) two of whom shall be elected by the class of carrier described in clause a of subsection 1;

(b) two of whom shall be elected by the class of carrier described in clause b of subsection 1;

(c) two of whom shall be elected by the class of carrier described in clause c of subsection 1; and

(d) one of whom shall be elected unanimously by the directors so elected and shall act as Chairman throughout his term as director.

(4) The members of Medical Carriers Incorporated shall be assessed annually for,

(a) the moneys required for the operation of the corporation; and

(b) moneys required for the operation of pooling arrangements.

(5) The proportion of the total assessment to be levied in any year to be borne by each member shall be determined in an equitable manner by the board of directors of the corporation and confirmed by at least two-thirds of the votes cast by representatives of members, such representatives being present in person or represented by proxy and entitled to vote at any annual general or special general meeting of the members of the corporation.

(4) If the members fail to confirm the assessments or if two or more members give notice to the board of directors that they question the equity of an assessment, the matter

shall be referred for decision to a board of three arbitrators, one to be named by the members licensed to undertake the business of accident and sickness insurance under *The Insurance Act*, one to be named by all other members, and one to be named by a judge of the Supreme Court upon the application of the other two arbitrators.

(5) The arbitrators shall have all the powers of arbitrators under *The Arbitrations Act* and may at any time and from time to time proceed in such manner as they think fit on such notice as they deem reasonable.

(6) The award of the arbitrators or of a majority of them shall be made within thirty days of the referral of the matter to them, and it is final and binding on all members.

9. The initial subscription for a standard medical services insurance contract or a standard in-hospital medical services insurance contract shall not exceed the appropriate maximum subscription in effect at the date of the application for the contract.

10. No carrier shall maintain in force, make or renew, or make any payment under, any medical services insurance contract unless the carrier complies with sections 5 and 7.

11. A resident who is not a dependant, or the dependent spouse of such resident, is entitled to have a family or an individual standard medical services insurance contract or standard in-hospital medical services insurance contract issued to him if his application therefor is made during an open enrolment period and the subscription therefor is paid in advance.

12. Where a person qualifies to apply for a standard medical services insurance contract or a standard in-hospital medical services insurance contract only after the expiration of an open enrolment period, he is entitled to have the contract for which he applies issued to him if his application therefor is made and the subscription therefor paid within thirty-one days following the day upon which he so qualifies.

(6) If the members fail to confirm the assessments or if two or more members give notice to the board of directors that they question the equity of an assessment, the matter shall be referred for decision to a board of three independent arbitrators, one to be named by the class of member described in clause a of subsection 1, one to be named by the class of member described in clause b of subsection 1, and one to be named by the class of member described in clause c of subsection 1.

(7) The arbitrators shall have all the powers of arbitrators under *The Arbitrations Act* and may at any time and from time to time proceed in such manner as they think fit on such notice as they deem reasonable.

(8) The award of the arbitrators or of a majority of them shall be made within thirty days of the referral of the matter to them, and it is final and binding on all members.

9. The initial subscription for a standard medical services insurance contract or a standard medical services co-insurance contract shall not exceed the appropriate maximum subscription in effect at the date of the application for the contract.

10. No carrier shall maintain in force, make or renew, or make any payment under, any medical services insurance contract unless the carrier complies with sections 5 and 7.

11. A resident who is not a dependant, or the dependent spouse of such resident, is entitled to have a family or an individual standard medical services insurance contract or standard medical services co-insurance contract issued to him if his application therefor is made during an open enrolment period and the subscription therefor is paid in advance.

12. Where a person qualifies to apply for a standard medical services insurance contract or a standard medical services co-insurance contract only after the expiration of an open enrolment period, he is entitled to have the contract for which he applies issued to him if his application therefor is made and the subscription therefor paid within thirty-one days following the date upon which he so qualifies.

13. Where a resident who is not a dependant, or the dependent spouse of such a resident, ceases to be covered after the expiration of an open enrolment period under a group medical services insurance contract issued by a carrier, such resident or such spouse is entitled to have a standard medical services insurance contract or a standard in-hospital medical services insurance contract issued to him by such carrier if his application therefor is made and the subscription therefor paid within thirty-one days following the day upon which he ceased to be covered under such group contract.

14. The coverage provided by a standard medical services insurance contract or a standard in-hospital medical services insurance contract issued under section 11, 12 or 13 is not subject to,

(*a*) a waiting period or any limitation of benefits with respect to pregnancy or resulting child-birth or miscarriage or other conditions that result directly or indirectly therefrom; or

(*b*) a waiting period or any limitation of benefits with respect to a pre-existing physical or mental infirmity or condition.

13.--(1) Where a resident who is not a dependant, or the dependent spouse of such resident, ceases to be covered after the expiration of an open enrolment period under a group medical services insurance contract issued by a carrier, such resident or such spouse is entitled to have a standard medical services insurance contract or a standard medical services co-insurance contract issued to him by such carrier if his application therefor is made and the subscription therefor paid within thirty-one days following the day upon which he ceases to be covered under such group medical services insurance contract.

(2) All waiting periods or limitation of benefits under the standard medical services insurance contract or the standard medical services co-insurance contract issued pursuant to this section shall be calculated from the effective date of coverage of the covered person under the group medical services insurance contract.

(3) Notwithstanding the provisions of subsection 1, a carrier that has been exempt from providing or selling standard medical services insurance contracts or standard medical services co-insurance contracts on an individual or family basis by Medical Carriers Incorporated pursuant to section 5 shall be responsible for obtaining or providing coverage for such resident or such spouse up to the first day of the fifth month following the date coverage ceases under the group medical services insurance contract of such exempt carrier.

14. The coverage provided by a standard medical services insurance contract or a standard medical services co-insurance contract issued under section 11 or 12 shall become effective on the first day of the month immediately following the date application is made and the subscription is paid and shall not be subject to,

(a) a waiting period or any limitation of benefits with respect to pregnancy or resulting child-birth or miscarriage or other conditions that result directly or indirectly therefrom; or

(b) a waiting period or any limitation of benefits with respect to pre-existing physical or mental infirmity or condition.

15. Subject to section 18, where the application of a resident who is not a dependant, or the dependent spouse of such a resident, for a standard medical services insurance contract or a standard in-hospital medical services insurance contract is not made and the subscription paid therefor within the period prescribed by section 11, 12 or 13, as the case may be, such resident or spouse may nevertheless apply for a standard medical services insurance contract or a standard in-hospital medical services insurance contract at any time, and, upon payment of the subscription and the late enrolment fee prescribed by Medical Carriers Incorporated, a contract shall be issued to such resident or spouse subject to the following limitation of benefits:

1. No benefit shall accrue for medical or surgical care or services rendered to a covered person during the three months immediately following the date of the contract.

2. No benefit shall accrue for medical or surgical care or services rendered to a covered person during the ten months immediately following the date of the contract if such costs arise from pregnancy or resulting child-birth or miscarriage or conditions that result directly or indirectly therefrom.

16. Where a standard medical services insurance contract or a standard in-hospital medical services insurance contract is issued and the subscription paid therefor during the initial open enrolment period, it shall, for a period of two years from the day on which this Act came into force,

(*a*) not be terminated by the carrier except for misrepresentation or non-payment of the subscription; and

(*b*) require a subscription not to exceed the maximum monthly subscription rates as follows:

	Standard Medical Services Insurance Contract	Standard In-Hospital Medical Services Insurance Contract
1. Resident....	X	Y
2. Single family maximum....	2½ X	2½ Y

15. Subject to section 18, where the application of a resident who is not a dependant, or a dependent spouse of such resident, for a standard medical services insurance contract or a standard medical services co-insurance contract is not made and the subscription paid therefor within the period prescribed by section 11, 12 or 13, as the case may be, such resident or spouse may nevertheless apply for a standard medical services insurance contract or a standard medical services co-insurance contract at any time, and, upon payment of the subscription and any late enrolment fee prescribed by Medical Carriers Incorporated, a contract shall be issued to such resident or spouse which shall become effective from the first day of the fourth month following the date of such application and payment, provided no benefit shall accrue for medical or surgical care or services rendered to a covered person during the six months immediately following the effective date of the contract if such costs arise from pregnancy or resulting child-birth or miscarriage or conditions that result directly or indirectly therefrom.

16. Where a standard medical services insurance contract or a standard medical services co-insurance contract is issued on an individual or family basis and the subscription paid therefor, during the period of two years from the day on which this Act comes into force, it shall, until the expiry of such two-year period,

(a) be not terminated by the carrier except as provided in section 16b, section 16c or section 16d; and

(b) provide for a subscription not to exceed the maximum monthly subscription rates as follows:

	Standard Medical Services Insurance Contract	Standard Medical Services Co-Insurance Contract
1. Individual	$ 6.25	$4.00
2. Family of Two	$12.50	$8.00
3. Family of Three or More	$16.00	$11.00

17. All benefits under a standard medical services insurance contract or a standard in-hospital medical services insurance contract during the two-year period specified in section 16 shall be computed on the basis of the Ontario Medical Association's schedule of fees in effect on the day this Act came into force, and thereafter shall be computed on the basis of the Ontario Medical Association's schedule of fees in effect from time to time.

16a. A contractholder shall be entitled to pay the subscription under a standard medical services insurance contract or a standard medical services co-insurance contract at least as frequently as quarter-yearly.

16b. Every standard medical services insurance contract and every standard medical services co-insurance contract shall provide that it becomes void with respect to any covered person upon the expiration of ninety days from the date the person ceases to make his principal place of residence in Ontario.

16c.--(1) Every standard medical services insurance contract and every standard medical services co-insurance contract shall provide that it becomes void for non-payment of subscription.

(2) Where a standard medical services insurance contract or a standard medical services co-insurance contract becomes void for non-payment of subscription, if the contractholder applies, within thirty days thereafter, for reinstatement and pays the required subscription, the carrier shall reinstate the contract without loss of benefits.

16d. A carrier may cancel a standard medical services insurance contract or a standard medical services co-insurance contract or the benefits of a covered person thereunder for misrepresentation or continuous misuse of services.

17. All benefits provided under a standard medical services insurance contract or a standard medical services co-insurance contract during the two-year period specified in section 16 shall be determined on the basis of the Ontario Medical Association's schedule of fees in effect for the year 1962, and after the expiration of that two-year period shall be determined on the basis of the Ontario Medical Association's schedule of fees in effect from time to time.

18.—(1) After the expiration of the two-year period specified in section 16,

(*a*) any carrier may from time to time, but not more often than once in any year, adjust the rate of subscription in accordance with its normal business practice, but any such adjustment shall be on a class-risk basis and not on an individual or family basis and shall in no event exceed the maximum subscription for the time being in force; and

(*b*) Medical Carriers Incorporated may at any time, but not fewer than sixty days and not more than ninety days before the end of a year, with the consent of the Superintendent, adjust the maximum subscription rate.

(2) If the Superintendent does not within thirty days of the date of application by Medical Carriers Incorporated consent to the adjustment of the maximum subscription rate, the matter shall be referred for decision to a board of three arbitrators, one to be named by the members licensed to undertake the business of accident and sickness insurance under *The Insurance Act*, one to be named by all other members, and one to be named by a judge of the Supreme Court upon the application of the other two arbitrators.

(3) The arbitrators shall have all the powers of arbitrators under *The Arbitrations Act* and may at any time and from time to time proceed in such manner as they think fit on such notice as they deem reasonable.

(4) The award of the arbitrators or of a majority of them shall be made within thirty days of the referral of the matter to them, and it is final and binding on all members.

19.—(1) Subject to section 16, any carrier may, upon giving sixty days notice in writing to the Minister and to the insured in the manner prescribed in the contract, cancel all but not part of its medical services insurance contracts.

18.--(1) After the expiration of the two-year period specified in section 16,

(a) any carrier may from time to time adjust the rate of subscription in accordance with its normal business practice, but any such adjustment shall, in the case of an individual or family contract, be on a class-risk basis and not on an individual or family basis and shall in no event exceed the maximum subscription for the time being in force;

(b) Medical Carriers Incorporated may at any time, with the consent of the Superintendent, adjust the maximum subscription rate; and

(c) Medical Carriers Incorporated shall give carriers at least sixty days notice in writing before any change in the maximum subscription rate becomes effective.

(2) If the Superintendent does not within thirty days of the date of application by Medical Carriers Incorporated consent to the adjustment of the maximum subscription rate, the matter shall be referred for decision to a board of three arbitrators, one to be named by the class of member described in clause a of subsection 1 of section 8, one to be named by the class of member described in clause b of subsection 1 of section 8, and one to be named by the class of member described in clause c of subsection 1 of section 8.

(3) The arbitrators shall have all the powers of arbitrators under *The Arbitrations Act* and may at any time and from time to time proceed in such manner as they think fit on such notice as they deem reasonable.

(4) The award of the arbitrators or a majority of them shall be made within thirty days of the referral of the matter to them, and it shall be final and binding on all members of Medical Carriers Incorporated and the Superintendent.

19.--(1) Subject to section 16, a carrier may, for reasons other than those set out in section 16d, cancel a standard medical services insurance contract or a standard medical services co-insurance contract only if such carrier gives sixty days notice in writing to the Minister and to the insured in the manner prescribed in the contract, and cancels all but not part of its medical services insurance contracts, and this provision shall prevail notwithstanding any provision pertaining to non-cancellability contained in any medical services insurance contracts.

(2) Upon the expiry of such period of sixty days, the licence issued to the carrier under this Act automatically terminates.

(3) Any carrier that cancels its medical services insurance contracts under subsection 1 shall, in the notice of cancellation given under that subsection, state that the covered persons may, within a period of sixty days from the date of the notice, make application to any other carrier for a standard medical services insurance contract or a standard in-hospital medical services insurance contract, and such other carrier, upon receipt of an application and the subscription therefor, shall issue a standard medical services insurance contract or a standard in-hospital medical services insurance contract, but the contract shall not be subject to,

(*a*) a waiting period or any limitation of benefits with respect to pregnancy or resulting child-birth or miscarriage or any other condition that results directly or indirectly therefrom; or

(*b*) a waiting period or any limitation of benefits with respect to a pre-existing physical or mental infirmity or condition.

(4) Notwithstanding anything in this Act, any carrier that cancels its medical services insurance contracts under subsection 1 shall, subject to receipt of proper notice and proof of claim within the times prescribed in the contract, remain liable to the date of cancellation for all benefits to which a covered person is entitled under the contract to the date of cancellation, and the carrier shall refund on a *pro rata* basis any unearned subscription.

20.—(1) Where a person who is covered by a standard medical services insurance contract or a standard in-hospital medical services insurance contract makes a claim under that contract and has, in force at the time a claim arises under that contract, any other medical services insurance coverage, no benefit is payable under that contract,

(*a*) if the other coverage is on a group basis; or

(2) Upon the expiry of such period of sixty days, the licence issued to the carrier under this Act automatically terminates.

(3) Any carrier that cancels its medical services insurance contracts under subsection 1 shall, in the notice of cancellation given under that subsection, state that the covered person may, within a period of sixty days from the date of the notice, make application to any other carrier for a standard medical services insurance contract or a standard medical services co-insurance contract, and such other carrier, upon receipt of an application and the subscription therefor, shall issue a standard medical services insurance contract or a standard medical services co-insurance contract, the waiting period and limitation of benefits with respect to which shall be calculated from the effective date of coverage of the covered person under the prior medical services insurance contract.

(4) Notwithstanding anything in this Act, any carrier that cancels its medical services insurance contracts under subsection 1 shall, subject to receipt of proper notice and proof of claim within the times prescribed in the contract, remain liable to the date of cancellation for all benefits to which a covered person is entitled under the contract to the date of cancellation, and the carrier shall refund on a *pro rata* basis any unearned subscription.

20.--(1) Every standard medical services insurance contract and every standard medical services co-insurance contract shall provide that where a covered person makes a claim and at the time the claim arises has in force any other contract of medical services insurance, the liability under the standard medical services insurance contract or the standard medical services co-insurance contract shall in no event exceed the difference between the amount of the claim and the amount payable under the other contract if,

(a) both contracts are on a group basis but the effective date of coverage under the standard medical services insurance contract or the standard medical services co-insurance contract is subsequent to the effective date of coverage under the other contract; or

23. In the event of conflict between any provision of this Act and any provision of any other Act, the provision of this Act prevails.

24. This Act comes into force on a day to be named by the Lieutenant Governor by his proclamation.

25. This Act may be cited as *The Medical Services Insurance Act, 1962-63.*

SCHEDULE A

BENEFITS PROVIDED BY A STANDARD MEDICAL SERVICES INSURANCE CONTRACT

Necessary professional services of a physician, wherever rendered, unless excepted under this Act or under this Schedule.

Exceptions:

1. Annual or periodic health examinations.

(see Exception 9)

2. Services that a covered person is entitled to receive without charge.

23. In the event of conflict between any provision of this Act and any provision of any other Act, the provision of this Act prevails.

24. This Act comes into force on a day to be named by the Lieutenant Governor by his proclamation.

25. This Act may be cited as *The Medical Services Insurance Act, 1962-63.*

SCHEDULE A

BENEFITS PROVIDED BY A STANDARD MEDICAL SERVICES INSURANCE CONTRACT

Expenses incurred by a covered person for necessary personal professional services of a physician, wherever rendered, unless excepted under this Act or this Schedule.

Exceptions:

1. Annual or periodic health examinations or any services or examinations for the purpose of,

   (a) an application for insurance or under a requirement for keeping insurance in force; or

   (b) an application for admission to or continuance at or in a school, college, university, camp or an association; or

   (c) employment, or the continuance of employment, or pursuant to the request of an employer or other person in authority; or

   (d) a passport, visa or other similar document.

2. Services to which a covered person is entitled and which he does receive without charge, including,

   (a) services received when he is a patient in any type of institution or special hospital when such services are paid for by the said institution or special hospital;

   (b) services obtained without charge by law or for which there is no actual charge made to him for any other reason;

3. Laboratory and other diagnostic procedures rendered as hospital services to the extent that these are provided for under the plan of hospital care insurance under *The Hospital Services Commission Act*; dental services; ambulance services; nursing services; dressings and cast materials; use of operating, plaster, or fracture rooms; services of government or commercial laboratories; drugs, vaccines, biological sera or extracts or their synthetic substitutes; eye glasses; special appliances; oxygen; physical therapy and other similar treatments.

4. Medical, surgical or obstetrical services when the covered person is a patient in a sanatorium, institution or special hospital for tuberculosis, mental illness or disease, alcoholism, epilepsy, or drug addiction, where such services are paid for by the sanatorium, institution or special hospital.

5. Services with respect to conditions that do not interfere with the covered person's bodily functions, or with respect to treatment for cosmetic purposes.

6. Newborn-infant care rendered by the physician delivering the infant.

7. Mileage.

8. Advice by telephone.

(c) services required in respect of an accident or sickness covered by any workmen's compensation law or similar legislation; and

(d) services for which no charge would be made in the absence of the insurance evidenced by a standard medical services insurance contract.

3. Laboratory and other diagnostic procedures rendered as hospital services to the extent that these are provided for under the plan of hospital care insurance under The Hospital Services Commission Act; dental care including X-Ray and anaesthetist services; ambulance services; nursing services; dressings and cast materials; use of operating, plaster, or fracture rooms; services of government or commercial laboratories; drugs, vaccines, biological sera or extracts or their synthetic substitutes; eye glasses; special appliances; oxygen; physical therapy and other similar treatments.

(Deleted)

4. Services with respect to conditions that are not detrimental to the health of the covered person or with respect to treatment for cosmetic purposes.

(Deleted)

5. Expenses for travelling time or mileage.

6. Advice by telephone.

9. Any services or examinations for the purpose of,

   (*a*) an application for insurance or under a requirement for keeping insurance in force;

   (*b*) an application for admission to or continuance at or in a school, college, university, camp or an association;

   (*c*) employment, or the continuance of employment, or pursuant to the request of an employer or other person in authority;

   (*d*) a passport, visa or other similar document.

10. Group inoculation or inoculations pursuant to a statute or by-law or regulation thereunder.

11. Refractions for safety glasses.

12. Services rendered by a physician pursuant to an arrangement for rendering services to the employees of an employer or to members of an association.

SCHEDULE B

BENEFITS PROVIDED BY A STANDARD IN-HOSPITAL MEDICAL SERVICES INSURANCE CONTRACT

Necessary professional services of a physician rendered to an admitted bed patient in a hospital approved for the purposes of the plan of hospital care insurance under *The Hospital Services Commission Act*, unless excepted under this Act or under Schedule A.

SCHEDULE C

The classes of persons for whom, if they are in needy circumstances, the Minister may purchase standard medical services insurance contracts under clause *a* of section 3 of this Act are those who are in receipt of benefits under any of the following Acts:

1. *The Blind Persons' Allowances Act.*
2. *The Disabled Persons' Allowances Act.*
3. *The General Welfare Assistance Act.*
4. *The Mothers' Allowances Act.*
5. *The Old Age Assistance Act.*
6. The *Old Age Security Act* (Canada).
7. *The Rehabilitation Services Act.*

(see Exception 1)

(Deleted)

7. Refractions.

8. Services rendered by a physician pursuant to an arrangement for rendering services to the employees of an employer or to members of an association.

SCHEDULE B

BENEFITS PROVIDED BY A STANDARD MEDICAL SERVICES CO-INSURANCE CONTRACT

Expenses incurred by a covered person for necessary personal professional services of a physician, wherever rendered, unless excepted by this Act or Schedule A, but subject to,

(a) a deductible provision of $25.00 per person with a maximum deductible of $50.00 per family in each calendar year to be calculated from the first day of January; and

(b) a 20% co-insurance provision for expenses incurred for necessary professional services of a physician.

SCHEDULE C

The classes of persons for whom, if they are in needy circumstances, the Minister may purchase standard medical services insurance contracts under clause *a* of section 3 of this Act are those who are in receipt of benefits under any of the following Acts:

1. *The Blind Persons' Allowances Act.*
2. *The Disabled Persons' Allowances Act.*
3. *The General Welfare Assistance Act.*
4. *The Mothers' Allowances Act.*
5. *The Old Age Assistance Act.*
6. The *Old Age Security Act* (Canada).
7. *The Rehabilitation Services Act.*

REPORT ON ENROLMENT UNDER ALBERTA MEDICAL PLAN

1. Background

The details of the Alberta Medical Plan were first announced to the people of Alberta on June 25th, 1963.

The initial "open enrolment period" commenced July 1st whereby all applications received by September 30th became effective October 1st, without a further enrolment waiting period. The "open enrolment period" was subsequently extended to October 11th because of the volume of applications being received during the last few days of September.

At times other than during "open enrolment periods" by law coverage is effective from the first day of the fourth month following the date of application.

The knowledge and skills acquired in Alberta could form a useful basis for other similar programs.

2. Enrolment - Alberta Medical Plan

Prior to introduction of the Alberta Medical Plan, an estimated 650,000 persons or 63% of the population were covered by M.S.I. and other carriers for medical services benefits of various types. In addition some 60,000 people, representing recipients of government pensions and assistance allowances, were covered by arrangement between the Alberta government and the Alberta College of Physicians and Surgeons.

While an accurate count of those currently covered by all insurance companies and M.S.I. will not be available for some months, it has recently been estimated that a total of 1,100,000 Alberta residents are now protected by a prepayment arrangement for medical care, including those in receipt of public welfare benefits, Armed Forces and persons under miscellaneous federal and municipal plans. The figure represents 81% of the population.

(continued)

It is significant that a total of 705,026 persons were covered by Alberta Medical Plan alone, or 52.2% of the population, at conclusion of the open enrolment period and including the transfer of existing M.S.I. contracts to Alberta Medical Plan coverage.

3. Enrolment of Persons Eligible for Either Level of Government Subsidy

At the end of the first "open enrolment period" a total of 171,468 persons enrolled in the Alberta Medical Plan under government subsidization of premiums.

Of all persons covered as of October 1st, approximately one-quarter are in receipt of government subsidy of premiums.

During this enrolment period, more than 75% of all new applications from persons who probably had no prior coverage were from persons eligible for government subsidy.

Prior to implementation of the Alberta Medical Plan, it was estimated that a total of 450,000 persons were eligible for government subsidy, either as a single person or a member of a qualifying family. But it must be noted that within this total there exist certain blocks of persons who are not apt to apply for the subsidy. Such persons include

(a) many thousands of Indians in the province who are already eligible for medical benefits under federal legislation,

(b) a significant number of persons with incomes low enough to qualify for subsidy but who are already protected by adequate group insurance plans partly or wholly paid for by employers,

(c) certain religious orders and social groups holding wealth and property communally.

All of these groups were included in the estimate of 450,000 subsidy-eligible people.

(continued)

4. General Comments

All figures quoted in this report refer only to enrolment for coverage effective October 1st, 1963. Enrolment is still continuing, subject to the waiting period described earlier, and while an estimate of the number of applications being received by all carriers is not available, M.S.I. alone estimates it is receiving about 1,000 applications each month. It is likely that a high percentage of these are from persons eligible for subsidy.

Immediately it was introduced, the Alberta Medical Plan achieved the objective of making broad protection universally available. Enrolment for coverage effective October 1st must be regarded as only the beginning of the public's response.

On December 27th, 1963 the Hon. J. Donovan Ross, Alberta Minister of Health said: "On the basis of the government's experience with the Plan, we expect enrolment to continue to increase until virtually everyone in the province who wants to prepay their medical care costs will be covered." "Moreover," he added, "this coverage has been achieved with no disruption in the high standard of medical care to which the people of Alberta are accustomed."

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Toronto, Ontario
January 29th, 1964.